CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Advancing Comprehensive Primary Care Update on Integrated BH Program

Care Transformation Collaborative of R.I.

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BROWN

Terminology

Expert Consensus Definition of Integrated Care

- Rendered by a practice team of primary care and behavioral health providers, working together with patients and families and using a **systematic** and **cost-effective** approach to provide patient centered care [1]

1. Davis, M., Balasubramanian, B.A., Waller, E., Miller, B.F., Green, L.A., & Cohen, D.J. (2013). Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together. *Journal of American Board of Family Medicine, 26* (5): 588-602. Available at http://www.jabfm.org/content/26/5/588.full.pdf+html

Terminology

- Collaborative care=working **with** primary care team [2]
- Integrated care=working **within** primary care team [2]

2. Collins,C., Hewson, D.L., Munger, R. and Wade, T. (2010). Evolving Models of Behavioral Health Integration in Primary Care. Milbank Memorial Fund. Available at http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf

Terminology

Coordinated	Colocated	Integrated
Routine screening for behavioral health problems conducted in primary care setting	Medical services and behavioral health services located in the same facility	Medical services and behavioral health services located either in the same facility or in separate locations
Referral relationship between primary care and behavioral health	Referral process for medical cases to be seen by behavioral specialists	One treatment plan with behavioral and medical elements
Routine exchange of information between both treatment settings to bridge cultural differences	Enhanced informal communication between the primary care and the behavioral health due to proximity	Typically, a team working together to deliver care, using a prearranged protocol

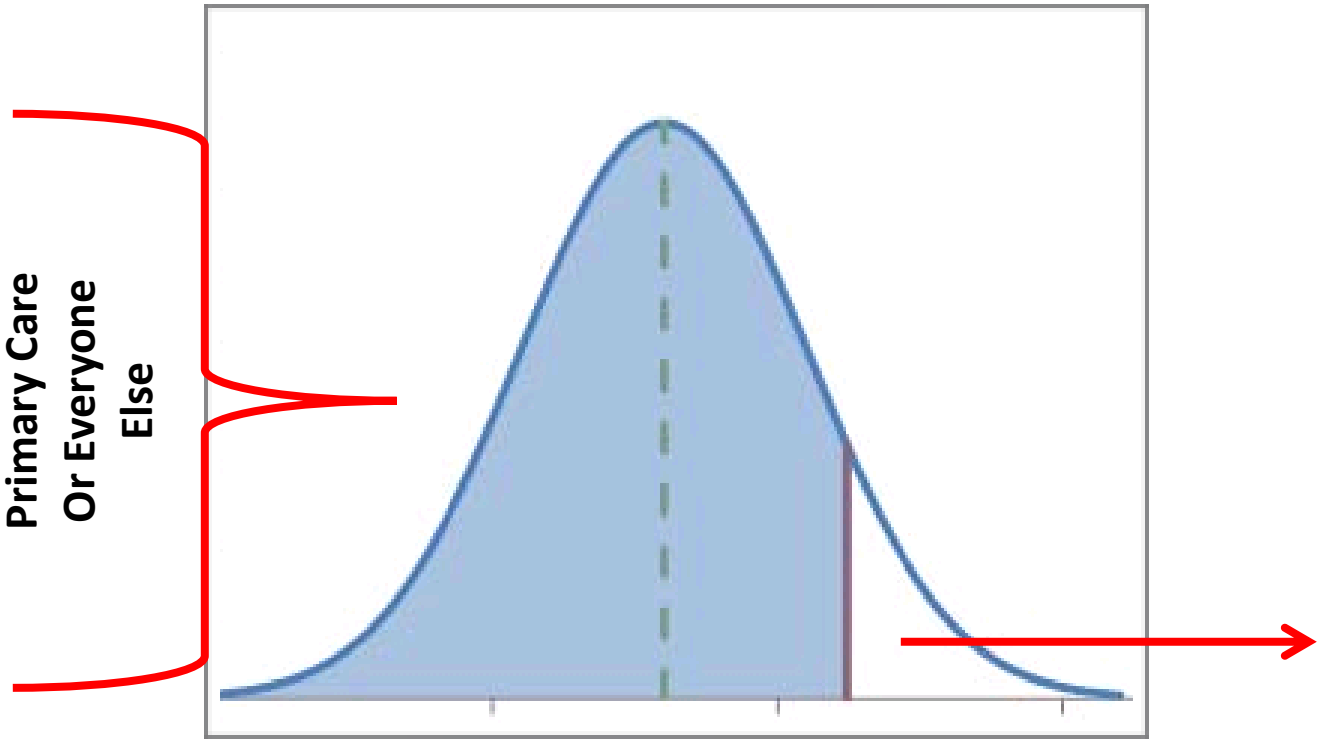
Adapted from Blount 2003

Terminology

Coordinated	Colocated	Integrated
Primary care provider delivers behavioral health interventions using brief algorithms	Consultation between the behavioral health and medical providers to increase the skills of both groups	Teams composed of a physician and one or more of the following: physician's assistant, nurse practitioner, nurse, case manager, family advocate, behavioral health therapist
Connections made between the patient and resources in the community	Increase in the level and quality of behavioral health services offered	
	Significant reduction of "no-shows" for behavioral health treatment	Use of a database to track the care of patients who are screened into behavioral health services

Adapted from Blount 2003

Primary Care: Perfect Melting Pot



Serious Mental Illness
5.4% Adult
5-9% Child

CTC-RI Overview

The States only multi-payer clinical and payment transformation organization.

- **Established in 2008 – incorporated as a 501c3 in 2015 --23 member Board with broad stakeholder representation**
  - **Vision: Rhode Islanders enjoy excellent health and quality of life**.
  - **Mission: To lead the transformation of primary care in Rhode Island in the context of an integrated healthcare system**; and to improve the quality of life, the patient experience of care, the affordability of care, and the health of populations we serve.
  - **Approach: CTC-RI brings together key stakeholders** to implement, evaluate, refine and spread models to deliver, pay for, and sustain high quality comprehensive primary care.

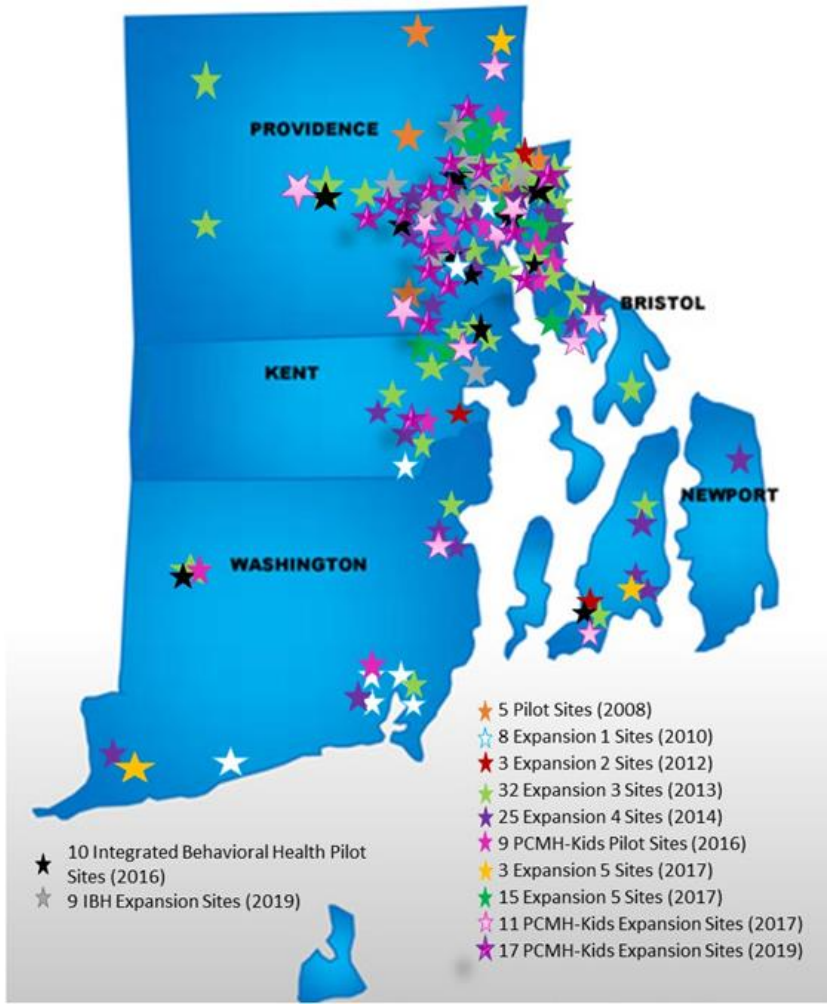
Goals

- Increase Capacity and Access to Patient-Centered Medical Homes (PCMH)
- Improve Quality and Patient Experience
- Reduce Cost of Care
- Improve Population Health
- Improve Provider Satisfaction (“Fostering joy in work”)

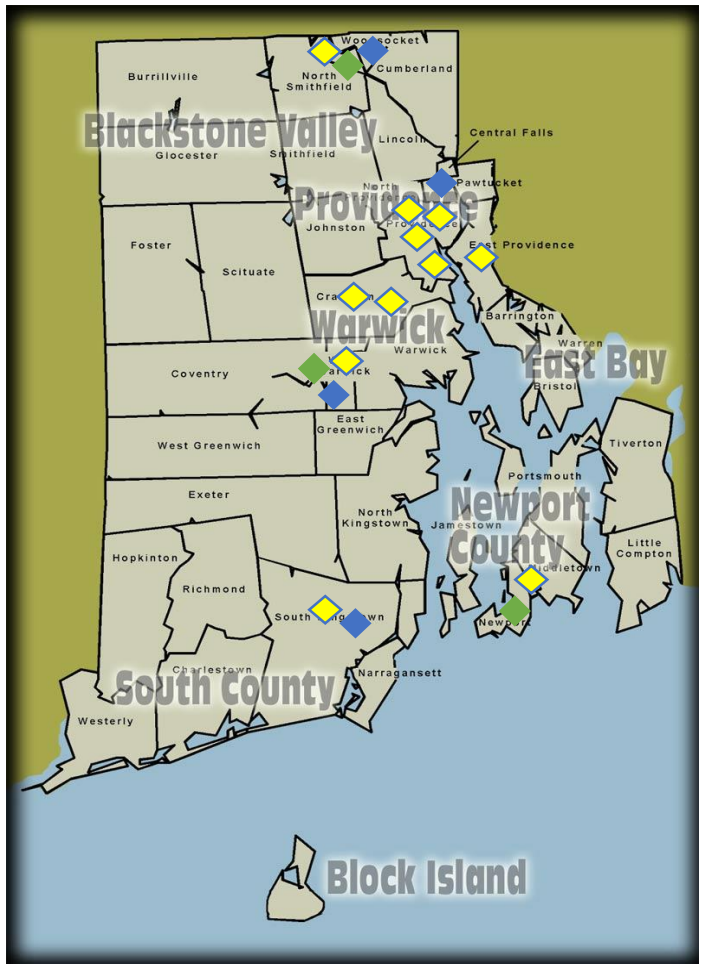
Expanding PCMH

The Care Transformation Collaborative of Rhode Island has a growing impact across the state, and includes:

- **124 primary practices**, including internal medicine, family medicine, pediatric practices; 19 adult primary care practices are part of integrated behavioral health initiative.
- Approximately **695,000 Rhode Islanders** receive their care from one of our practices.
- **800 providers** across our adult and pediatric practices.
- Investment from **every health insurance plan** in Rhode Island, including private and public plans.
- **All Federally Qualified Health Centers** in Rhode Island participate in our Collaborative.
- CTC practices demonstrate **lower total cost of care by $217 million in 2016** when compared to non-patient centered medical homes in Rhode Island, according to data from the state's All-Payer Claims Database.



Expanding Care in the Neighborhoods



CHT and SBIRT locations:

- Woonsocket
- Blackstone Valley
- Providence
- West Warwick
- Newport
- South County

New ◆ Existing ◆

SBIRT locations:

- Several sites including:
  - Dept of Corrections
  - Kent Hospital
  - Butler Hospital
  - CCAP
  - RIPIN
  - The Providence Center

Advancing Integrated Behavioral Health in Primary Care

Presentation of the IBH Pilot Program

- Unmet Need
- Project Goals and Audience
- Program Overview
- Qualitative Evaluation
- APCD Comparative Cost and Utilization Data
- Workforce Development
- Sustainability
- Main Takeaways

Unmet Need

- RI ranks 5th Nationally for severity based on 13 mental illness indicators
- RI ranks 7th Nationally in opioid overdose deaths
- Two-thirds of RI's mental health clients have at least one serious medical condition
- In the U.S., most patients with mental health needs rely solely on their PCP
- Primary care / behavioral health staff have little training in providing integrated behavioral health services in primary care

Integrated Behavioral Health Project Goals and Audience

Goal 1: Reach higher levels of quality through **universal screening**

Goal 2: Increase access to **brief intervention** for patients with moderate depression, anxiety, SUD and co-occurring chronic conditions

Goal 3: Provide **care coordination** and intervention for patients with high emergency department (ED) utilization /and behavioral health condition

Goal 4: **Increase patient self care** management skills: chronic condition and behavioral health need

Goal 5: Determine **cost savings** that primary care can achieve by decreasing ED visits and inpatient hospitalization

Target Audience(s): Ten Patient Centered Medical Home (PCMH) primary care practices serving 42,000 adults

Funding Partners

RHODE ISLAND FOUNDATION

TUFTS Health Plan

State of Rhode Island

IBH Program Overview

3-year program with 2 waves of practices

IBH Cohort 1	IBH Cohort 2
Associates in Primary Care	Coastal Medical - Hillside Family Medicine
East Bay Community Action Program (E. Prov & Newport)	Providence Community Health Centers - Capitol Hill
Providence Community Health Centers - Chafee	Providence Community Health Centers - Prairie Ave
Tri-County Community Action	University Medicine - Governor St
Women's Medicine Collaborative	Wood River Health Services

Key Program Components:

- Onsite IBH Practice Facilitation: support culture change, workflows, billing
- Universal Screening: depression, anxiety, substance use disorder
- Embedded IBH Clinician : warm hand offs, pre-visit planning, huddles
- Three PDSA Cycles : screening, high ED, chronic conditions
- Quarterly Best Practice Sharing: data driven improvement, content experts

Practice Payment: $35,000 over 2 Years

Infrastructure Payment	1st payment: month 1	2nd payment: month 5
$15,000 prorated per 5000 attributed lives	$10,000	$5,000
Incentive Payment	**Year 1: month 12**	**Year 2: month 24**
$10,000 each year for meeting screening targets	Depression: 70% Anxiety: 50% Substance use disorder: 50%	Depression: 90% Anxiety: 70% Substance use disorder: 70%

Qualitative Evaluation

Providers love it: “When I say how much I love having integrated behavioral health, it is that I can't imagine primary care without it. **It just makes so much sense to me to have those resources all in the same place** because it's so important. So I love it. I can't speak highly enough of it.” *(Medical Provider)*

Value of deliberate screening: "**I'm surprised especially with the anxiety screener that there's more out there than I knew about.** I was talking to somebody yesterday. You think this wouldn't be useful information. I know the patient pretty well, and the patients, if they had an issue, I'm sure they would tell me. But it comes up on the screener." *(Medical Provider)*

Impact on ED use: “One of the things we identified [through the program] was somebody was going to the ER almost every other day, and it was due to anxiety. So he was given tools to control that, and it actually empowered him. He felt like he had taken control of this issue. And his ER visits dropped right off.

He was being seen here [at the primary care practice] more frequently, but that's okay. **We'd rather he come here than go to the ER**.” *(Practice Coordinator)*

Lessons Learned

New Unmet or Changing Needs

- **Copays** are a barrier to treatment
- **Billing and coding** difficult to navigate
- Workforce Development IBH **practice facilitators** and IBH clinicians

Things to Do Differently

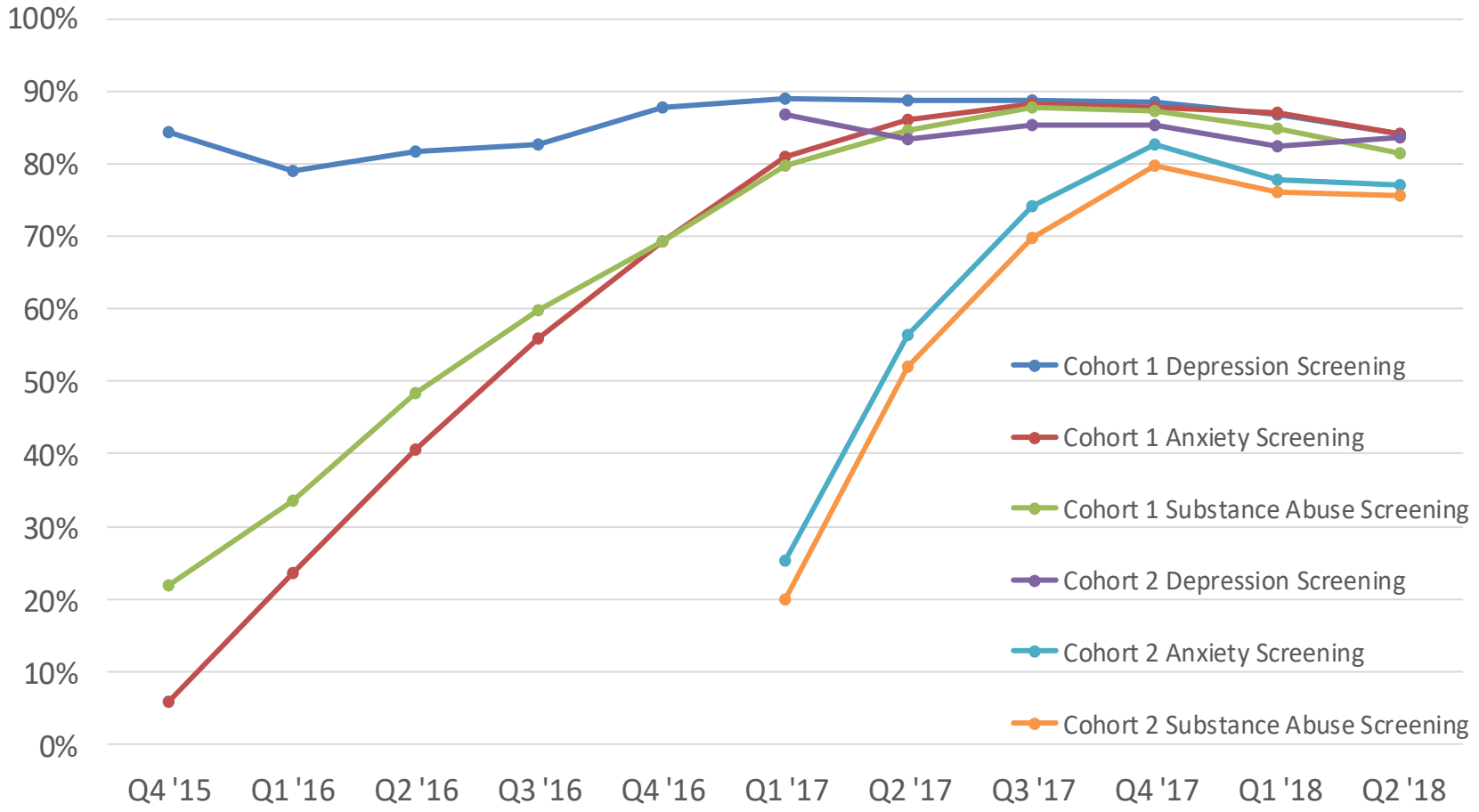
- Give practices 3 to 6 months to **prepare for implementation**
  - ✓ Billing and coding
  - ✓ Credentialing
  - ✓ EHR modifications
  - ✓ Workflow
  - ✓ Staff training

What Would Be Helpful Post-Pilot

- **Build workforce** for Integrated Care
- **Pilot APM** for IBH in primary care
- **Leverage legislative action**; 1 copay in primary care; treat screenings as preventive services
- Address needs of **small practices through CHT**

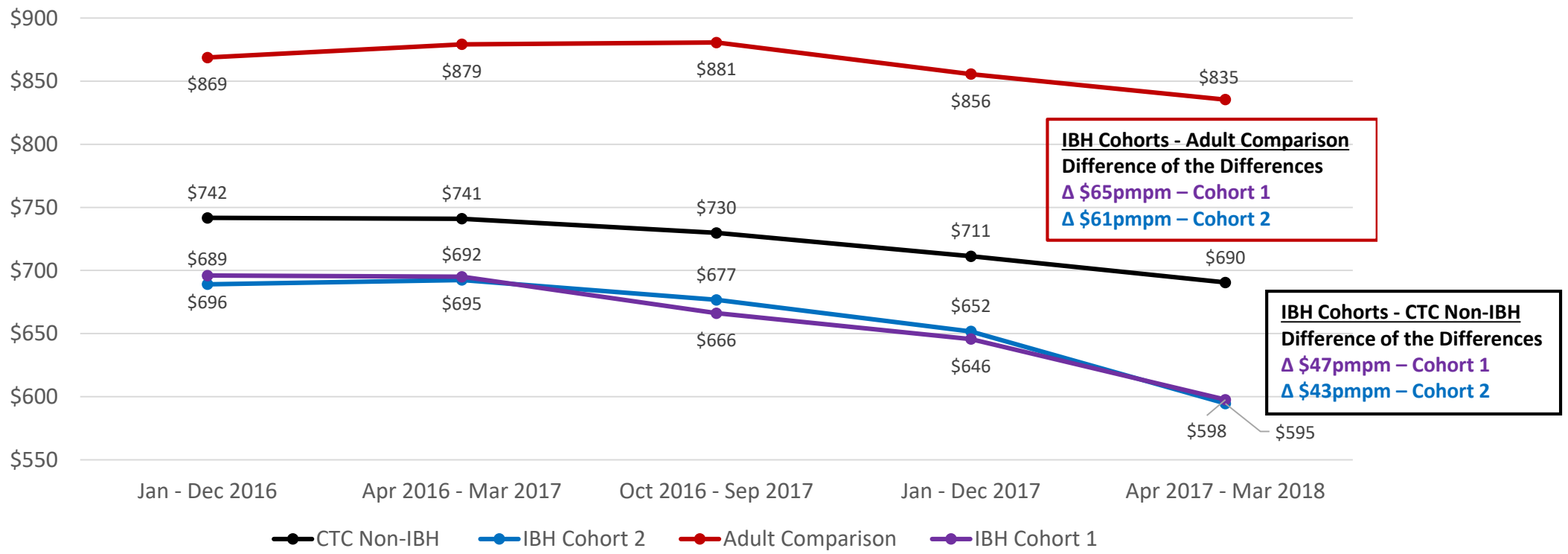
Screening and Utilization Outcome Results

PDSA: Universal Screening Cohort 1 & 2



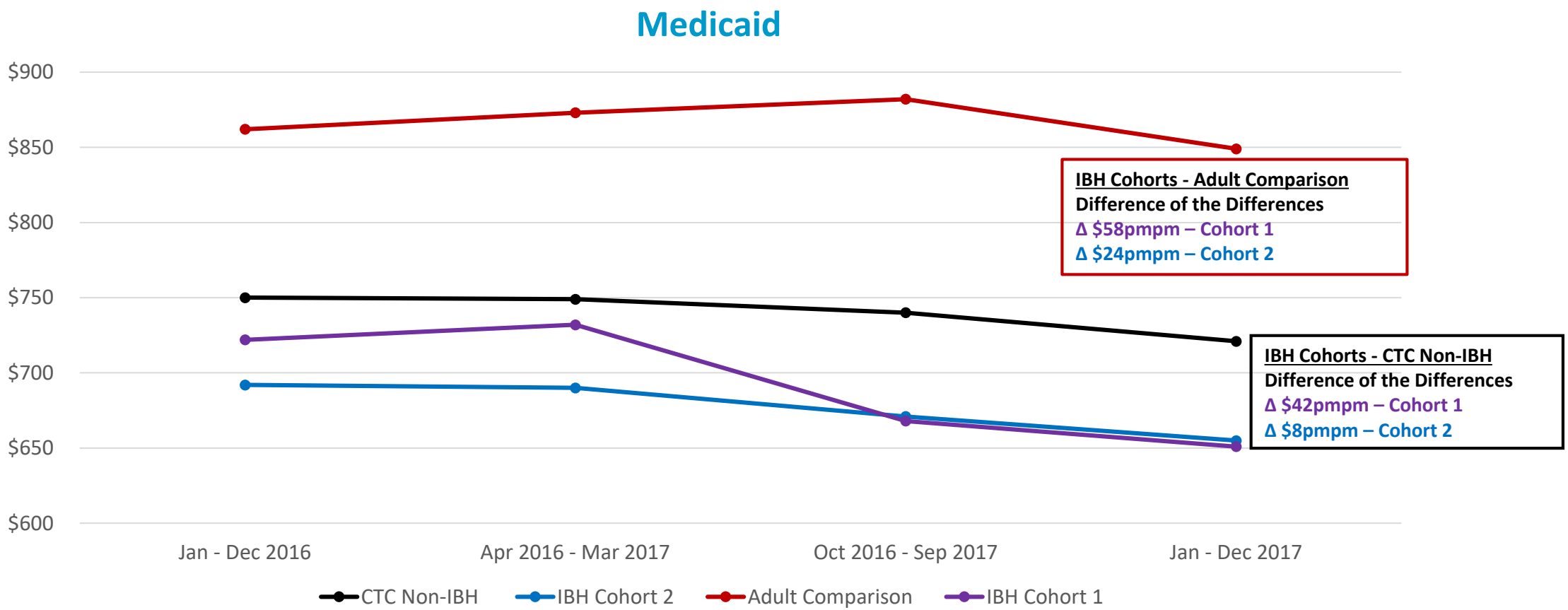
Better Care - Lower Costs

Total Medical & Pharmacy Costs (with Exclusions) Risk-Adjusted (Cost per Member-Month)



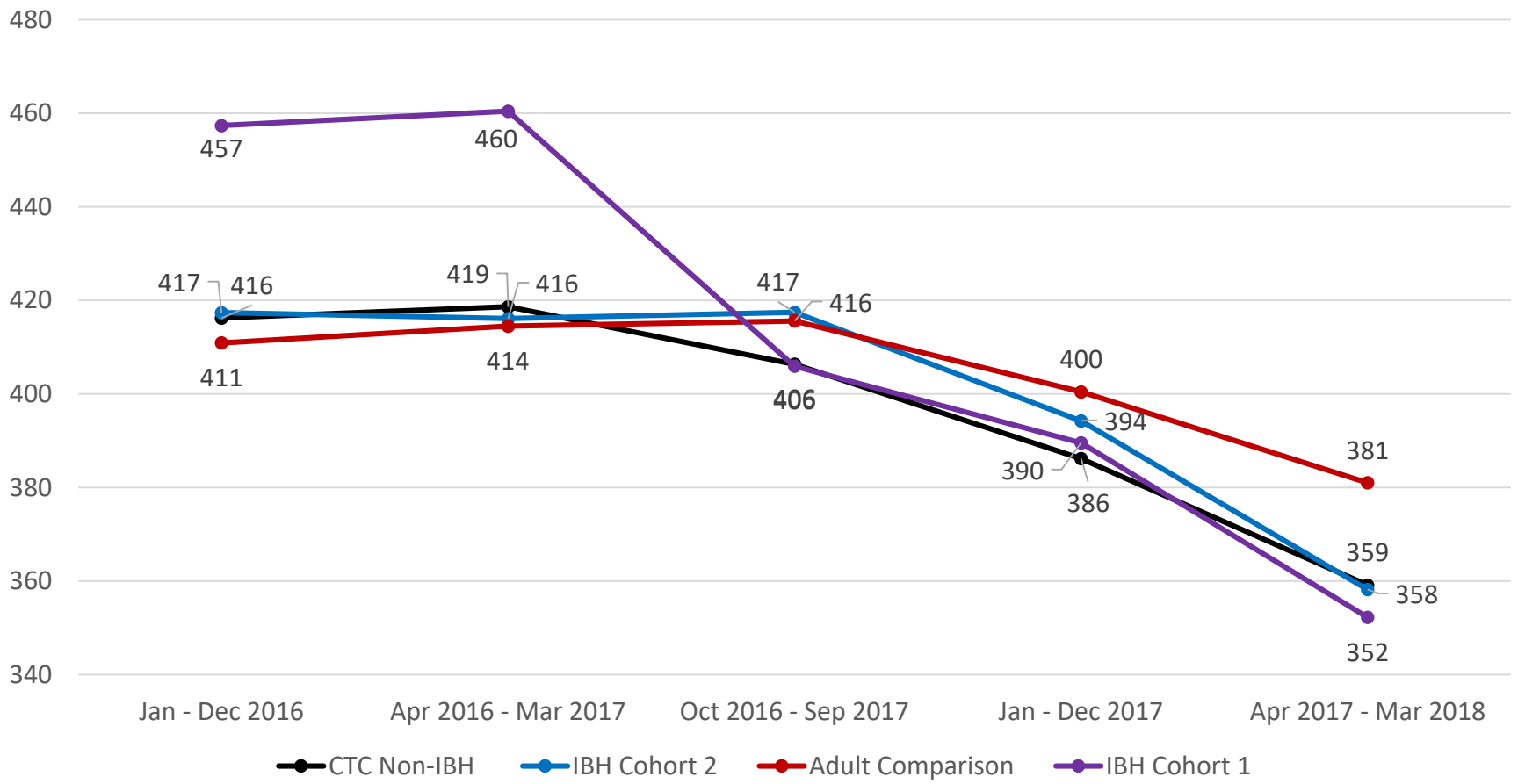
Data Source: Rhode Island All Payer Claims Database

Total Medical & Pharmacy Costs (with Exclusions) Risk-Adjusted



Data Source: Rhode Island All Payer Claims Database

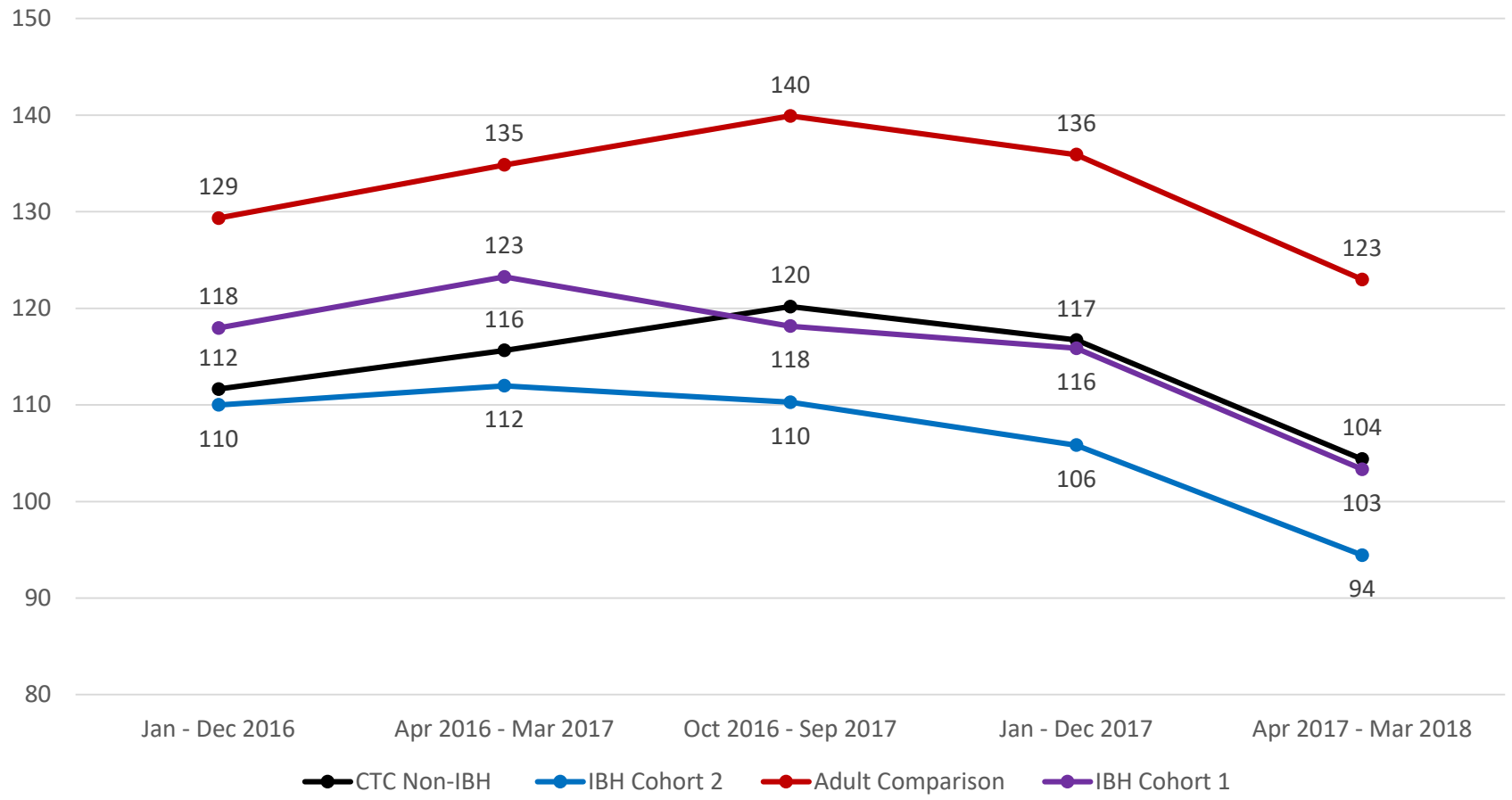
Emergency Department Visits
Risk-Adjusted (Visits per 1,000 Member-Years Count)



Data Source: Rhode Island All Payer Claims Database

Inpatient Utilization Acute Care Discharges

Risk-Adjusted (Visits per 1,000 Member-Years)



Data Source: Rhode Island All Payer Claims Database

Workforce Development

Integrated behavioral health practice facilitation in patient centered medical homes: A promising application.
Sarah S. Roderick, Nelly Burdette, Debra Hurwitz, Pano Yeracaris
Family, Systems & Health. 2017 Jun; 35(2): 227–237.

Next Steps / Sustainability

- Quantitative Evaluation -Brown University – APCD data using a matched comparison group due out Q2- 2019
- Partnering with Systems of Care: spread across the life cycle
- Payment Reform: IBH Alternative Payment Model
- Legislative Action: co-pay and credentialing
- Educate: Present and Publish

Main Takeaways

Integrated Behavioral Health in Primary Care Works
Improved access, patient care & reduces costs

Onsite practice facilitation by IBH subject matter experts supports culture change for successful implementation

More action is needed

- APM for Integrated Behavioral Health in Primary Care
- No copays for behavioral health screenings
- Eliminate second copay for same day visit
- Continue workforce development
- Credentialing

The Next Frontier - Pediatric IBH

Goal: Address behavioral health needs before families are in crisis

Funding Partners: BCBSRI through the RIF Behavioral Health Grant, UnitedHealthcare & Tufts

Program Overview: 3-year program with 2 waves of practices

Pediatric IBH Cohort 1	Pediatric IBH Cohort 2
Anchor Pediatrics	Coastal Medical – Bald Hill
Comprehensive Community Action Program	Coastal Medical - Waterman
Hasbro Pediatric Primary Care	Hasbro Medicine Pediatric Primary Care
Tri-County Community Action Agency	Northern Rhode Island Pediatrics

Key Program Components:

- Onsite IBH Practice Facilitation: support culture change, workflows, billing
- Universal Screening for 3 out of 5: depression, anxiety, substance use disorder, middle childhood and postpartum depression
- Embedded IBH Clinician : warm hand offs, pre-visit planning, huddles
- Two PDSA Cycles : screening, population health need addressed through community resources
- Quarterly Best Practice Sharing: data driven improvement, content experts

Practice Payment:

- Infrastructure payment support of $18,000 in the first year
- Up to $10,000 in incentive payments based on meeting service delivery requirements and screening targets ($5000 year 1; $5000 year 2)

Final Thought

"If primary care treats the **body**,
and mental health treats the **head**,
integrated care is rediscovering the **neck**."

Alexander Blount, Ed.D.
Retired Professor of Clinical Family Medicine,
Director of Behavioral Science,
Department of Family Medicine and Community Health,
University of Massachusetts

Questions?